intrinsi

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Naturopathic Intake Form
ADULT

FULL NAME (surname, first name):	**HOME Phone:**
Today's date:	**CELL Phone:**
Address:	
Male/ Female **AGE**: **DATE OF BIRTH** (M/D/Y):	**EMAIL**:
Emergency Contact (Name & Relationship)**:**	**Emergency Contact Phone:**
Medical Doctor's Name:	Current Occupation:
Other Health Practitioners Name/Type:	How did you find out about us? If you were referred by a person please provide their full name for our referral rewards program:

What are your most important health concerns in order of importance?

1.

2.

3.

4.

How committed are you towards making changes to help your concerns:
Little Moderately Very

Adult Naturopathic
Health History Questionnaire

When and where did you last receive healthcare? _____

When was the last time you had blood work done? _____

List any previous hospitalizations or surgeries:

_____

_____

_____

List any prescription or over-the-counter medications or natural supplements that you are currently taking and their strength:

_____

_____

_____

_____

List any allergies that you have, including environmental, food or medication:

Mother's age or age at death: _____
Health condition(s): _____

Father's age or age at death: _____
Health condition(s): _____

Sibling(s) age(s) or age(s) at death: _____
Health condition(s): _____

Do any members of <u>your immediate family</u> have any of the following? (Please circle if yes)

Allergies, Anemia, Arthritis, Asthma, Auto-immune disease, Cancer, Diabetes, Epilepsy, Heart attack, Heart disease, High blood pressure, Kidney disease, Liver disease, Mental illness, Osteoporosis, Stroke, Tuberculosis, Thyroid disease

Other_____

General

Weight _____ Height _____ Weight 1 year ago _____ Max weight _____ Ideal Weight_____

Adult Naturopathic
Health History Questionnaire

Habits

What are your main interests and hobbies?

Do you exercise? Y N
What form and how often?

Do you feel fatigued often	Y N	Do you awaken rested?	Y N
Do you eat three meals each day?	Y N	Average 6-8 hours sleep per day?	Y N
Do you drink soda pop?	Y N How many/day_____	Do you sleep well?	Y N
Drink Coffee?	Y N How many cups/day _____	Take vacations?	Y N
Do you use antacids?	Y N How often? _____	Have a spiritual practice?	Y N
Do you use laxatives?	Y N How often?_____		
Do you enjoy your work?	Y N		
Spend time outside?	Y N Hours/day? _____		
Read	Y N		
Watch television	Y N Hours/day? _____		
Use recreational drugs?	Y N	Been treated for drug dependence?	Y N
Use Alcoholic beverages?	Y N How often? _____	Been treated for alcoholism?	Y N
Use tobacco? Y N			

Are you particularly sensitive to perfumes, gasoline or other vapors_____
Have you ever had health problems when you put in new carpet, painted, or other refurbishing?_____
Do you use pesticides, herbicides or other chemicals around your home?_____

Review of systems

Please circle correct answer for the conditions below:
Y = current condition ***P = past condition***

Skin

Rashes	Y P	Eczema/Psoriasis	Y P	Hives	Y P
Acne/boils	Y P	Night sweats	Y P		

Head

Headache	Y P	Head injury	Y P	Migraine	Y P
Hair loss	Y P				

Eyes

Impaired vision	Y P	Eye pain	Y P	Double vision	Y P
Glaucoma	Y P				

Ears

Impaired hearing	Y P	Ringing	Y P	Earache	Y P
Dizziness	Y P	Frequent infections	Y P		

Adult Naturopathic
Health History Questionnaire

Nose and sinuses

Frequent colds	Y P	Nose bleeds	Y P	Stuffiness	Y P
Hay fever	Y P	Sinus problems	Y P		

Mouth and throat

Frequent colds	Y P	Gum problems	Y P	Hoarseness	Y P
Loss of taste	Y P	Cold sores	Y P	Sore throat	Y P

Neck

Lumps	Y P	Swollen glands	Y P
Goiter	Y P	Pain or stiffness	Y P

Respiratory

Cough	Y P	Spitting up blood	Y P	Sputum	Y P
Wheezing	Y P	Asthma	Y P	Bronchitis	Y P
Shortness of breath	Y P	Pneumonia	Y P	Emphysema	Y P
Difficult breathing	Y P	Pain on breathing	Y P	Tuberculosis	Y P

Cardiovascular

Heart disease	Y P	Angina	Y P	High blood pressure	Y P
Murmurs	Y P	Palpitations	Y P	Low blood pressure	Y P
Swelling of ankles	Y P	Chest pain	Y P		

Gastrointestinal

Indigestion	Y P	Heartburn	Y P	Hemorrhoids	Y P
Change in appetite	Y P	Nausea	Y P	Vomiting	Y P
Blood in stool	Y P	Jaundice (yellow skin)	Y P	Liver disease	Y P
Gall bladder disease	Y P	Ulcer	Y P	Diarrhea	Y P
Constipation	Y P	Bloating	Y P		

Bowel movements: how often?_____Is this a change?

Urinary

Pain on urination	Y P	Increased frequency	Y P	Frequency at night	Y P
Inability to hold urine	Y P	Frequent infections	Y P	Kidney stones	Y P
Urgency	Y P				

Female reproductive

Age menses began?_____ Average # of days? _____ Length of cycle? _____

Bleeding between periods	Y P	Irregular cycles	Y P	Pain during intercourse	Y P
Painful menses	Y P	Excessive flow	Y P	Difficulty conceiving	Y P
Menopausal symptoms	Y P	Sexual difficulties	Y P	Decreased libido	Y P
Sexually transmitted infections	Y P	Are you sexually active?	Y P		

Number of pregnancies _____ Number of live births _____Number of miscarriages_____
Number of abortions _____
Birth control Y P
Type of birth control _____

Do you do self breast exams?	Y N	Lumps	Y P
Breast pain or tenderness	Y N	Nipple discharge	Y P

Date of last:
Pap smear_____ Mammogram_____ DEXA scan_____

Adult Naturopathic
Health History Questionnaire

Male reproductive

Hernias	Y P	Testicular masses	Y P	Testicular pain	Y P
Are you sexually active? _____		Sexual difficulties	Y P	Prostate disease	Y P
Discharge	Y P	Sexually transmitted infections	Y P	Lesions or sores	Y P

Musculoskeletal

Joint pain or stiffness	Y P	Arthritis	Y P	Broken bones	Y P
Muscle pain/cramps	Y P	Osteoporosis	Y P	Osteopenia	Y P
Tremors	Y P				

Peripheral vascular

Deep leg pain	Y P	Cold hands/feet	Y P	Varicose veins	Y P
Thrombophlebitis	Y P				

Neurological

Fainting	Y P	Seizure	Y P	Paralysis	Y P
Muscle weakness	Y P	Loss of memory	Y P	Numbness/tingling	Y P

Emotional

Depression	Y P	Suicidal	Y P	Anxiety	Y P
Mood swings	Y P	Tension	Y P	Anger/irritable	Y P
Eating disorder	Y P				

Endocrine

Hypothyroid	Y P	Hyperthyroid	Y P	Diabetes	Y P
Excessive thirst	Y P	Excessive hunger	Y P	Heat/cold intolerance	Y P

Blood

Anemia	Y P	Easy bleeding or bruising	Y P

Service & Payment Policy

Clients are responsible for charges incurred, both for services rendered and for cancellations with less than 24 hours notice.

We require 24 hours notice for cancellations or changes to appointments. Please note that a cancellation fee of 100% will be charged for appointments missed or cancelled without 24 hours notice. Without appropriate notice, cancellations affect three parties. First, you miss the benefits that you would have acquired from a treatment. Second, we as therapists lose revenue, and third, another client who could have taken the appointment misses out on a treatment.

We encourage clients to check with their individual insurance providers regarding services and credentials covered. It is the client's responsibility to ensure compliance with their insurance plan for reimbursement purposes. Intrinsi is happy to provide any information that you may require for insurance purposes but are not responsible for any rejected insurance claims.

Your signature indicates that you have read and agree to the Service & Payment policy.

Patient (or guardian) Signature: _____ Date: _____